Washington State Department of Social & Health Services

CHILDREN'S ADMINISTRATION (CA)
DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

FOSTER PARENT REIMBURSEMENT CLAIM CHECKLIST

TO BE COMPLETED BY FOSTER PARENT

- ☐ Complete a current Foster Parent Reimbursement Claim form, DSHS 18-400. For claims involving individuals who are not licensed foster parents, complete the Foster Parent Liability Claim form, DSHS 18-400A.
- ☐ For each item claimed, provide the date of occurrence; state the specific injury/damage/loss item; describe the circumstances of the injury/damage/loss; indicate what supervision was being provided at the time of the incident; the steps taken to reduce the risk of the occurrence; and the steps to be taken to protect against similar future occurrences.
- ☐ For property damage/loss items, indicate the original purchase cost, and the date originally purchased.
- ☐ Provide the full name, home address, and contact telephone numbers for all available witnesses to the injury/damage/loss occurrence.
- ☐ Sign and date the form; send completed form and attachments to the child's CA social worker or DDD case manager.

PROPERTY DAMAGE/LOSS ITEMS:

- ☐ Property damage: Send a detailed estimate or final repair/cleaning bill signed by retailer to substantiate claim. **NOTE:** Labor costs are not paid when a foster parent does their own work; however, we will pay for the cost of materials needed to make the repairs.
- ☐ Property loss and property damage that cannot be repaired or cleaned: Send two replacement estimates detailed and signed by different retailers **or** the replacement purchase receipt for comparable item of similar kind and quality (same model, brand, features, etc.) and a copy of the original purchase receipt if available. Two pictures from identified merchandise media sources (with the description and price indicated) will suffice as comparable estimates.
- ☐ Property damages/losses relating to theft, vandalism, and fire: Send a copy of the police or fire department report along with any follow-up investigation findings for claims over $250.00 ($100.00 for money).
- ☐ Photos which show the damage may be required if property damage is not seen by CA social worker or DDD case manager.

EMERGENCY MEDICAL TREATMENT AND DENTAL/VISION EXPENSES:

- ☐ Medical/Dental/Vision: Send copy of provider bill/insurance statement and for injuries, the medical discharge notes. Payment is limited to costs not payable elsewhere.
- ☐ Dental: Comparable replacement of dental appliances paid (if not repairable) up to maximum under Plan.
- ☐ Vision: Send the replacement purchase receipt **or** two estimates detailed and signed by different retailers for comparable replacement of eyeglasses/contacts (repair bill if repairable) and a copy of the original purchase receipt if available.

TO BE COMPLETED BY CA SOCIAL WORKER OR DDD CASE MANAGER

- ☐ Review claim for accuracy, completeness, timeliness, support documents, and signature.
- ☐ Complete the social worker section on Page 2 of the claim form, provide the case number and placement information for the involved child(ren); indicate your response to Questions 3 through 7; state the reason(s) why you do or do not concur; and provide any other pertinent information.
- ☐ For claims submitted more than ninety (90) days after an occurrence, include a statement indicating the reason for the delay in filing the claim. Claims not received by the DSHS Insurance Services Section within one year of an occurrence will be denied.
- ☐ Print your full name; indicate your office, region, mail stop, and telephone number; sign and date the claim form; and forward the original to the DSHS Insurance Services Section (ISS). (See distribution at the bottom of Page 2.)

Washington State Department of Social & Health Services

FOSTER PARENT REIMBURSEMENT CLAIM

INTERNAL USE ONLY

☐ Filed by Licensed Provider ☐ Filed by DDD Respite/VPP Provider

CLAIM VALUE (TOTAL AMOUNT REQUESTED)

Foster parents must complete this form to request reimbursement for property damages/losses and initial emergency medical treatment expenses incurred because of an act of your foster/respite care child. Claims must be submitted to the child's assigned CA social worker or DDD case manager within thirty (30) days of an injury/ damage/loss occurrence. Claims not filed in a timely manner may be denied. Claims not received by the DSHS Insurance Services Section within one year of an occurrence will be denied.

1. FOSTER PARENT/DDD RESPITE/VPP PROVIDER INFORMATION (PRINT)

NAME	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
	( )	( )

MAILING ADDRESS | CITY | STATE | ZIP CODE

2. RESPONSIBLE FOSTER/DDD RESPITE/VPP CHILD(REN) INFORMATION (PRINT LEGAL NAME)

LAST NAME	FIRST NAME	BIRTHDATE	STATUS (CHECK ONE)
			☐ Respite Child ☐ Foster Child
			☐ Respite Child ☐ Foster Child
			☐ Respite Child ☐ Foster Child

3. SUBSTANTIATING INFORMATION: COMPLETE THIS SECTION ON SEPARATE FORM FOR ADDITIONAL ITEMS (PRINT LEGIBLY)

FOR PROPERTY DAMAGE/LOSS ITEMS	ITEM 1	ITEM 2	ITEM 3
a. **Date of occurrence**			
b. **Damage/loss item** (i.e., television)			
c. **Original purchase cost/date originally purchased**	/	/	/
d. **Repair/cleaning cost** (for damaged items)			
e. **Comparable replacement costs** (For loss items and items which cannot be repaired. Attach a copy of replacement receipt or two retail estimates.) Receipt			
OR Estimate 1			
AND Estimate 2			
FOR EMERGENCY MEDICAL TREATMENT/DENTAL/VISION EXPENSE CLAIMS	ITEM 1	ITEM 2	ITEM 3
f. **Amount of bill** (attach copy of bill or statement)			
g. **Amount paid by insurance** (indicate N/A if none available) Attach copy of bill or statement.			

h. Circumstances: Describe **HOW** and **WHAT** specific injury, damage, or loss occurred. If needed, attach a separate sheet to continue your description statement.

i. Describe what supervision was being provided at the time the injury/damage/loss occurred and what steps had been taken to reduce the risk of the occurrence. Indicate what steps will be taken to protect against similar future occurrences.

4. SUBSTANTIATING DOCUMENTATION

Attach the required substantiating documents for all items claimed as stated on the claim checklist. Picture(s) of the damage may be required. A copy of the police or fire department report along with any follow-up investigation findings must be attached for claims over $250.00 relating to theft, vandalism, and fire ($100.00 for money). **Reimbursement will not be made without all the required documents/information.**

5. WITNESS(ES) TO THE INURY/DAMAGE/LOSS OCCURRENCE (PRINT)

NAME	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
	( )	( )
MAILING ADDRESS / CITY / STATE / ZIP CODE		
NAME	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
	( )	( )
MAILING ADDRESS / CITY / STATE / ZIP CODE		

6. CLAIM VALIDATION

SIGNATURE	DATE

DEPARTMENT USE ONLY

To be completed by CA social worker or DDD case manager: **Failure to provide all the required information will cause a delay in reimbursement to the foster parent.**

1. CHILDREN'S FIRST NAME AND CASE NUMBER(S)		2. PLACEMENT INFORMATION	
		to	☐ Still in home
		to	☐ Still in home
		to	☐ Still in home

Please answer the following:

3. I personally saw damage/injury. ☐ Yes ☐ No
4. Foster parent signed/dated claim. ☐ Yes ☐ No
5. All the requested information and required documentation is provided. ☐ Yes ☐ No
6. I verify that the claim occurred during authorized Foster Care/DDD Respite/VPP service. ☐ Yes ☐ No
7. I concur with payment of this claim. ☐ Yes ☐ No

8. STATE THE REASON(S) WHY YOU DO OR DO NOT CONCUR. PROVIDE ANY OTHER PERTINENT INFORMATION (ATTACH ADDITIONAL PAGE IF NECESSARY).

NAME OF SOCIAL WORKER/CASE MANAGER (PRINT)	FIELD OFFICE	REGION	MAIL STOP
SOCIAL WORKER/CASE MANAGER SIGNATURE	DATE	TELEPHONE NUMBER	
		( )	

ORIGINAL TO: DSHS INSURANCE SERVICES SECTION (ISS), PO BOX 45844, MAIL STOP 45844, OLYMPIA WA 98504-5844
COPY TO: Foster Parent/Respite Provider; Child's Service Record